Youth Suicide-Prevention Guidelines

for California Schools

2005

California Department of Education
Learning Support and Partnerships Division
Counseling, Student Support, and Service-Learning Office
1430 N Street, Suite 6408
Sacramento, California 95814
(916) 323-2183

Contents

The California Department of Education published *Suicide-Prevention Program for California Public Schools* in 1987. Since that time, much research has emerged regarding mental health issues and other determinants of suicide. California *Education Code* Section 49604 directs the State Superintendent of Public Instruction to provide training on suicide prevention to each school counselor and information on the availability of the suicide prevention curriculum developed by the California Department of Education (CDE). The CDE developed this resource to be available online to help schools recognize the behavior of potentially suicidal youths and other indicators and reduce the incidence of suicidal behavior. Additionally, this resource can help schools to cope with, and effectively respond to, suicide crises.

In 1996 the U.S. Surgeon General recognized suicide as a public health problem, declaring suicide the ninth leading cause of mortality in the United States. This ranking makes the number of suicides 50 percent higher than the number of homicides in 1996. The U.S. Public Health Service published *The Surgeon General's Call to Action to Prevent Suicide* in 1999 (*http://www.mentalhealth.org/suicideprevention/calltoaction.asp).*

Although the overall suicide rate among youths slowly declined during the 1990s, it remains unacceptably high.[1] The U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), reports that mental disorders (including depression), substance abuse disorders, and increased access to firearms are important reasons to make suicide-prevention plans. The CDC also advises that these plans include screening, referral, and crisis-intervention strategies for adolescents and young adults.[2]

The following information is compiled from a variety of sources and is offered to encourage schools to develop a schoolwide suicide-prevention plan and to answer questions about what to do should a suicide occur on campus.

PREVALENCE OF YOUTH SUICIDE

According to the 1996 Surgeon General's report, the rate of suicides among adolescents and young adults nearly tripled between 1952 and 1996. From 1980 to 1996, the rate of suicide among persons aged fifteen through nineteen years increased by 14 percent and among persons aged ten through fourteen years by 100 percent. Among persons aged fifteen through nineteen years, firearms-related suicides accounted for 96 percent of the increase in the rate of suicide since 1980. For young people fifteen through twenty-four years old, suicide is currently the third leading cause

[1] Lubell, K. M., Swahn, M. H., Crosby, A. E., & Kegler, S. K. (2004, June 11). Methods of suicide among persons aged 10-19 years – United States, 1992-2001. *Morbidity and Mortality Weekly Report,* 53(22),1. *http://www.cdc.gov/mmwr/index2004.htm*

[2] Acosta, D., et al. (2001, December 7). School health guidelines to prevent unintentional injuries and violence. *Morbidity and Mortality Weekly Report,* 50 (RR 22),14. *http://www.cdc.gov/mmwr/indrr_2001.html*

of death, exceeded only by unintentional injury and homicide. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS (acquired immunodeficiency syndrome), birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.[3]

A national *Youth Risk Behavior Survey* conducted in 2003 by the U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion, found 16.5 percent of high school students had considered suicide so seriously that they made a plan to carry it out, and 8.5 percent had attempted it. Each year 520,000 teens need medical care after attempting to kill themselves, and nearly 5,000 youths ages fifteen through nineteen kill themselves annually. [4]

The CDC also analyzed data from participating students in grades nine through twelve who responded to questions about whether they had attempted suicide and about whether they had participated in physical fighting in the preceding 12 months. The results of that analysis indicate that students who reported attempting suicide were nearly four times more likely to also have reported fighting than those who reported not attempting suicide. Although suicide is commonly associated with anxiety, depression, and social withdrawal, research suggests a link between violent behaviors directed at oneself and violent behavior directed at others among adolescents.

These results would indicate that schools should develop prevention programs that seek to reduce both suicidal and violent behaviors. Additionally, because prevalence of this correlation was determined to be highest in the ninth grade, these efforts might be most effective if started before students reach high school.[5]

Identifying Risk Factors

A plan for preventing, intervening, and responding to youth suicide should consider the risk factors associated with completed suicides. The American Association of Suicidology published the following list of potential factors of risk of suicide among youths:

- Presence of a psychiatric disorder (e.g., depression, drug or alcohol disorder, behavior disorder, conduct disorder such as incarceration, running away)

---

[3] U.S. Public Health Service. (1999). *Surgeon General's Call to Action to Prevent Suicide.* Washington, DC [p.3-4]. *http://www.mentalhealth.org/suicideprevention/calltoaction.asp*

[4] National Center for Chronic Disease Prevention and Health Promotion. *Key Results from the 2003 Youth Risk Behavior Survey, including mortality data on leading causes of death. http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?path=byHT&ByVar=CI&cat=1&quest=Q25&year=2003&loc=XX* and *http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?path=byHT&ByVar=CI&cat=1&quest=Q26&year=2003&loc=XX*

[5] Lubell, K. M., Swahn, M. H., Crosby, A. E., & Kegler, S. K. (2004, June 11**)**. Methods of suicide among persons aged 10-19 years – United States, 1992-2001. *Morbidity and Mortality Weekly Report,* 53(22), 474. *http://www.cdc.gov/mmwr/index2004.htm*

- Expression of thoughts of suicide, death, dying, or the afterlife (in a context of sadness, boredom, hopelessness, or negativity)

- Impulsive and/or aggressive behavior; frequent expressions of rage

- Increasing use of drugs or alcohol

- Exposure to another's suicidal behavior

- Recent severe stressor (e.g., dealing with sexual orientation, an unplanned pregnancy, significant real or anticipated loss)

- Persistent and/or ongoing physical or emotional stressors (e.g., impaired parent/child relationship; trauma or physical abuse, sexual abuse)

- Family instability; significant family conflict

Studies also reveal additional common characteristics of youth suicide, such as the following:

- Most adolescent suicides occur after school hours in the teen's home.

- Although suicide rates vary somewhat by geographic location, within a typical high school classroom it is likely that three students (one boy and two girls) have attempted suicide in the past year.

- Not all adolescent attempters admit their intent. Therefore, any deliberate self-harming behaviors are to be considered as serious, and the youth should be evaluated further.

- Most adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to effect change in the behaviors or attitudes of others.[6]

Identifying Protective Factors

Identifying and understanding environmental risk factors is important. However, understanding how to develop and/or expand methods for building on protective factors in students is also essential.

Recent research explores a wide range of topics that have positive consequences for youths, including family dynamics, support from adults, school effectiveness, positive

[6] "Youth Suicide Fact Sheet," Washington, DC: *American Association of Suicidology*, March 19, 2004. *http://www.suicidology.org/associations/1045/files/YouthSuicide.pdf*

peer influence, value development, and social skills. From this research three models have emerged that promote the core building blocks of human development: resiliency, youth development, and developmental assets.

Research in the area of **resiliency** shows both the environmental and psychological factors that help children transcend adversity.

Research in **youth development** names a set of developmental factors (e.g., connection, competence, and empowerment) that should be cultivated in all youths who are between ten and twenty years of age.

The framework of **developmental assets** incorporates resiliency and youth development factors and is grounded in an exploration of human development based on theory and research.

Researcher and lecturer Peter L. Benson of the Search Institute in Minneapolis, Minnesota, studied the role of schools and communities in building developmental assets in youths. He reports that developmental assets, such as positive peer influence, restraint, and school engagement, protect against high-risk behaviors such as the use of alcohol and other drugs, depression, violence, and attempted suicide.

To review concepts of youth development in more detail, visit "Getting Results Update 1" at *http://www.gettingresults.org*.

School Community's Role in Youth Suicide Prevention

To prevent risky behavior and foster healthy, successful youths, school communities can promote positive things and identify the core building blocks of human development that every child and adolescent needs. The following protective factors are important to adolescent development:

- Family cohesion
- Connectedness to friends and school
- Self-perceived ability to cope with problems and influence outcomes
- Emotional wellness

A framework of developmental assets enables families, neighborhoods, congregations, employers, and youth organizations to unite and develop a plan for healthy adolescents. Some examples of how community groups can develop an environment supportive of youths and thereby help to prevent youth suicide and other negative behaviors are as follows:

- All community residents build caring relationships with children and adolescents and show caring through dialogue, listening, commendation of positive behavior, knowing children by name, acknowledging their presence, and involving them in making decisions.

- The religious community mobilizes to integrate relationships and to provide parent education, values, and structured opportunities for service to the community.

- Schools place a priority on becoming caring environments for all students, strengthening co-curricular activities, and using connection to parents to escalate involvement and reinforce the importance of family.

- Youth organizations train leaders and volunteers in asset-building strategies and offer a continuum of opportunities for youths to develop healthy relationships with adults and peers.

- Businesses that employ teenagers support and share teens' commitment to learning, values, and social competencies. Employers develop employee-friendly policies and provide ways for employees to build relationships with teens they employ. [7]

BUILDING SOLUTIONS THAT WORK

The World Health Organization (WHO), a United Nations specialized agency for health, urged member nations worldwide to address suicide in its document, *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* (1996). In July 2004 the WHO regional office for Europe's Health Evidence Network (HEN) synthesized research findings from systematic reviews to address which suicide preventive interventions were evaluated and published and which of them are supported by good-quality evidence. In its summary, HEN reported on a total of 30 primary and secondary suicide-preventive interventions.

Typically, *school-based* suicide-prevention programs focus on behavioral change and coping strategies in the general school populations. Lower suicidal tendencies were found in students with improved ego identification and coping skills. Programs that provided skill training and social support for at-risk students were found to be effective in reducing risk factors and enhancing protective factors.[8]

Another national youth suicide-prevention organization, the Australian Institute of Family Study, conducted an analysis from July 1995 to June 1999 to help build the capacity and systems of suicide-prevention efforts based on evidence of effectiveness. It

[7] Ibid.

[8] *For which strategies of suicide prevention is there evidence of effectiveness?* WHO Regional Office for Europe's Health Evidence Network (HEN), World Health Organization, July 2004.

examined program effects at three levels: outcomes, impacts, and changes in service and program delivery. The evaluation revealed no significant outcomes, no positive changes in individual or environmental risk (impact), but it demonstrated five positive themes for preventing suicide among young people. These five major themes are as follows:

1. Using a multidimensional approach that incorporates a full spectrum of interventions from multiple community partners

2. Increasing *access* to social services by young people, who generally underuse services and who could benefit the most from prevention and early intervention support

3. Engaging young people and developing appropriate responses to their needs (i.e., focusing on communication and challenging negative assumptions about young people)

4. Using interventions that are effective with young people (i.e., adequately holistic interventions that address all systems affecting the young person's health and welfare)

5. Building the capacity of existing services and programs rather than creating new ones [9]

Finally, the CDC noted two common themes generally incorporated into exemplary youth suicide-prevention programs it reviewed and included in its publication.[10] First, all programs contained strategies to enhance the identification of suicidal youths and referral to existing mental health resources. Second, strategies are designed to directly address the risk factors for youth suicide.

NATIONAL STRATEGY FOR SUICIDE PREVENTION

In the United States, representatives from several health organizations partnered to create a national strategy for suicide prevention. The suicide-prevention document that resulted includes the U.S. Surgeon General's national strategies and is available online at *http://www.mentalhealth.org/suicideprevention.*

The report contains both a blueprint for addressing suicide and recommendations that are the foundation for the *National Strategy for Suicide Prevention.* The partners responsible for its development included the U.S. Department of Health and Human Services, which encompasses the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service

[9] *National Youth Suicide Prevention Strategy for the Commonwealth of Australia*. (2000). Commonwealth of Australia. *http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-sp-nsps-index.htm*

[10] Ibid.

(IHS), the National Institute of Mental Health (NIMH), the Office of the Surgeon General, and the Substance Abuse and Mental Health Services Administration (SAMHSA). The Suicide Prevention Advocacy Network (SPAN) was also a partner. SPAN is a public grassroots advocacy organization made up of suicide survivors (persons close to someone who completed suicide), attempters of suicide, community activists, and health and mental health clinicians.

STATE EFFORTS IN SUICIDE PREVENTION

After the *Surgeon General's Call to Action,* which declared suicide, particularly adolescent suicide, to be a public health concern, SPAN-California (the California affiliate of the national organization SPAN), took the lead in developing California's Suicide-Prevention Plan. The U.S. Surgeon General encouraged states to make suicide prevention a priority and set national goals and objectives. Participants at the SPAN-California Suicide-Prevention Planning Conference in May 2004 worked on a recommended strategy that is posted on California's Suicide-Prevention Web site at *http://www.span-california.org.* The goals of the proposed plan are as follows:

1. Promote awareness that suicide is a preventable public health problem.

2. Develop broad-based support for suicide prevention.

3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental-health, substance-abuse, and suicide-prevention services.

4. Develop and implement suicide-prevention programs.

5. Promote efforts to reduce access to lethal means and methods of self-harm.

6. Implement training for recognition of at-risk behavior and delivery of effective treatment.

7. Develop and promote effective clinical and professional practices.

8. Increase access to community linkages with mental health and substance-abuse services.

9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment [industry] and news media.

10. Promote and support research on suicide and suicide prevention.

11. Improve and expand school campus surveillance systems.[11]

[11] Suicide Prevention Advocacy Network – California (SPAN-California), *SPAN Report,* June 7, 2004.

Some of the 57 objectives listed under each goal of the proposed *California Strategy for Suicide Prevention* pertain to youths and are as follows:

- Develop and implement suicide-prevention programs that build upon individual and community-level protective factors.

- Require suicide-prevention training in schools to prepare school counselors and health professionals.

- Provide training for teachers and other school staff to identify and respond to persons at risk of suicide.

- Conduct behavior risk surveys in nontraditional settings (e.g., juvenile detention facilities and homeless shelters) to better reach persons at risk of suicide.

- Promote research on suicide prevention in California universities, colleges, and other organizations.

- Develop and disseminate tools (e.g., Web sites and resource guides) for professionals and the public to gain access to information about mental-health and substance-abuse services.

- Develop guidelines for support programs for suicide survivors.

- Provide and promote guidelines for responsible suicide reporting practices.

- Establish a state council composed of entertainment [industry] and news media representatives, mental health professionals, and suicide-prevention experts to serve as a resource and to provide guidance to the media on the depiction of suicide and mental illness.

To review the entire draft of the *California Strategy for Suicide Prevention* document, visit the Web site of the Suicide Prevention Advocacy Network at *http://www.spancalifornia.org*.

Key Elements for School-Based Suicide-Prevention Programs

The key strategies that follow were distilled from exemplary suicide-prevention programs and focus on adolescent youths. The CDC[12] and others who reviewed and published the strategies presume that suicide-prevention plans at public schools involve the school community, integrate comprehensive health and mental health components,

[12] Centers for Disease Control and Prevention. (1992). *Youth Suicide Prevention Programs: A Resource Guide. http://www.cdc.gov/ncipc/pub-res/youthsui.htm*

consider resiliency and developmental asset frameworks, and reflect nationally and state-supported goals and objectives.[13]

Recommended School-Based Primary Suicide-Prevention Approach

A school-based primary suicide-prevention plan is a composite of strategies that schools may use to design a prevention plan, lessen students' thoughts of suicide, and decrease attempts and completion of suicide by students. All exemplary school-based prevention programs take the following steps:

- *Enlist the support of administration.* Whether or not a youth suicide-prevention plan is valued and/or successfully developed and implemented depends almost entirely on the support provided by school and school district administrators (e.g., superintendents, assistant superintendents, student services coordinators) and school site administrators (e.g., school principals and assistant principals).

- *Develop and adopt a districtwide youth suicide-prevention policy.* A policy adopted by the school board supports the design and implementation of a suicide-prevention plan and demonstrates the school district administration's commitment to a proactive school-based suicide-prevention approach. Sample board policies and administrative regulations regarding suicide prevention are located at the California School Boards Association Web site: *http://www.csba.org/ps/samintro.htm.* The identifying numbers are BP 5141.52 and AR 5141.52.

- *Institute training for faculty and all school staff.* The CDC presents guiding principles for establishing school social environments that promote safety in *School Health Guidelines to Prevent Unintentional Injuries and Violence Report* (2001). These principles state, "For all school personnel, provide staff development services that impart the knowledge, skills, and confidence to effectively promote safety and prevent unintentional injuries, violence, and suicide, and support students in their efforts to do the same" (p. 13). The report may be reviewed at *http://www.cdc.gov/mmwr/PDF/RR/RR5022.pdf.*

  With training, staff will have the knowledge, attitudes, and skills necessary to help determine the level of students' connections to school and the level of risk and protective factors students possess, as well as assist them to identify warning signs, suicide myths, and school community resources. The Suicide Prevention Resource Center of the American Foundation for Suicide Prevention lists evidence-based practices in suicide-prevention programs and opportunities for training on its Web site: *http://www.sprc.org/whatweoffer/ebp_factsheets.asp.*

[13] Kimokeo, Deborah A. (2004). *School-based suicide prevention program development: Useful and efficacious guidelines.* Unpublished doctoral dissertation, Teachers College/Columbia University; National Mental Health Information Center. (2001). *National strategy for suicide prevention: Goals and objectives for action,* p.1. *http://www.mentalhealth.samhsa.gov/publications/browse.asp*

- *Institute a school crisis response team.*[14] Identify a diverse group of individual school administrators, faculty members, parents, students, and representatives of community agencies (e.g., social welfare, mental health services, members of the faith community, juvenile justice, and related family support systems) to develop a plan and conduct practice drills during the school year for how to respond to crises. Doing so can ensure leadership presence in each school building. Also, enlisting members of the local police, fire department, and medical facility to be part of the team will ensure appropriate and critical response.[15]

- *Institute parent/guardian education regarding youth suicide.* Providing parents and guardians with knowledge and skills about how to recognize behaviors that could indicate emotional instability or depression will make parents more likely to refer themselves and their children to community providers for help. One example of parent training curriculum is featured on the Web site of the Suicide Prevention Resource Center's Registry of Evidence-Based Practices in Suicide Prevention Programs. It features the parent version of "SOS: Signs of Suicide" at *http://www.sprc.org/whatweoffer/ebp_factsheets.asp.*

- *Institute community "gatekeeper" training.* It is important for parents and students to understand that the school is knowledgeable about resources to help depressed and suicidal adolescents and can help coordinate those resources. This training also helps adults and students understand and respond to the stigma associated with reaching into the community for support. Adult and student "gatekeeper" training programs are listed on the Web sites of Youth Suicide Prevention (*http://www.yspp.org/resources)* and the American Foundation for Suicide Prevention *(http://www.sprc.org/whatweoffer/ebp_factsheets.asp).*

- *Implement skills training and social support programs for students.* All students, particularly those at risk of failure, should receive developmentally appropriate training in problem-solving skills. One example for helping students develop their sense of personal control and accomplishment is referenced in a study conducted by the New York University Child Study Center. In an article summarizing the findings published in 2003, Dr. Richard Gallagher outlines methods used to teach students from grades three through eight about how to manage their schoolwork. He also created a systematic way to measure each child's level of skill.[16]

---

[14] California Department of Education. (2002). *Safe Schools A Planning Guide for Action.* Sacramento, CA: Author, p. 101.

[15] Dwyer, K., Osher, D., & Warger, C. (1998). *Early Warning, Timely Response: A Guide to Safe Schools.* Washington, DC: U.S. Department of Education, 27-28. *http://cecp.air.org/guide/guide.pdf*

[16] Gallagher, R., & staff of the NYU Child Study Center. (April 2003). Organizational skills for school success, *The Parent Letter* 1 (3).

The Center for School Counseling Outcome Research tested whether tutoring and counseling would improve a student's classroom behavior and increase self-esteem. The research indicates that a dropout prevention program that combines both academic tutoring and group counseling can benefit students in the areas of academic achievement, behavior, and self-esteem.[17]

Youth Violence: A Report of the Surgeon General summarizes studies and strategies that proved effective and ineffective. It concludes that programs and interventions that aim to improve youths' moral reasoning, problem-solving, and thinking skills are also effective approaches to reducing youth violence in high-risk populations.[18]

Providing youths with structured opportunities to perform meaningful service in the community or participate in community projects that support a commitment to learning, values, and social competencies can add social and personal skills that lead to confidence and a sense of accomplishment.

- *Implement school activities that increase students' connection to the school.* The *National Longitudinal Study on Adolescent Health*, a nationally representative study that examined how social contexts influence adolescent health and risk behaviors (*http://www.cpc.unc.edu/projects/addhealth*), found that adolescents perceive school connectedness as a leading protective factor against suicide. Activities that involve making personal choices and decisions, participation in after-school programs, clubs and activities, and a safe physical environment at school are also protective factors.

- *Develop supportive school-community partnerships.* Collaborative school-family-community partnerships share a commitment to create opportunities for students and continuous learning and growth for the community. The effort involves curricular, policy, fiscal, and social support strategies and can include law enforcement, psychiatric and health providers, and outside family and individual counseling agencies. One example of school-family-community partnership is The Unity Project: Creating a Circle of Awareness. The project was designed to facilitate a partnership to increase the academic and personal success of historically underachieving students. For more information about this project, visit the Northwest Regional Educational Laboratory's Web site at *http://www.nwrel.org/cfc*.

  Although few controlled studies of adolescents who attempt suicide reflect optimal approaches to suicide prevention, the findings are consistent regarding the need to provide age-appropriate training in social skills improvement.

---

[17] Dimmitt, C., & Hatch, T.(2003). Interventions for helping students at risk of dropping out of school. *Center for School Counseling Outcome Research, School Counseling Research Brief 1.3,* July 15, 2003. *http://www.umass.edu/schoolcounseling/briefs.htm*

[18] U.S. Surgeon General. (2005).*Youth violence: A report of the surgeon general.* Washington, DC: Author. *http://www.surgeongeneral.gov/library/youthviolence*

Recommended strategies range from incorporating skills training into standards-based instruction (e.g., a teacher could have his/her students analyze a story and point out the skills used by the characters that demonstrate their ability to cope with stress, anger, conflict), to enlisting the help of a trained therapist to help individual students identify negative feelings, correct irrational ideas, and become aware of available options.[19]

Learning how to cope with stressful situations, how to resolve conflict, how to best communicate, as well as learning appropriate assertiveness and decision-making skills, can help students more appropriately respond to the risk factors listed earlier.

Recommended School-Based Suicide-Intervention Approach

In its study the CDC found evidence to support the strategy of restricting access to lethal means of suicide (e.g., firearms and lethal dosages of drugs) to prevent some youths from completing suicide. However, none of the youth suicide-prevention programs it reviewed incorporated that strategy as a major focus.[20] This strategy has been recognized more recently by the Florida Mental Health Institute at the University of South Florida. The university developed a series of issue briefs regarding youth suicide prevention in 2003. Citing the *Journal of Emotional and Behavioral Disorders*, the *Journal of Primary Prevention*, and others, the Florida report states that parents need to be informed about research suggesting that guns in the home are a key risk factor in adolescent suicide and that the most common method for death by suicide in the United States is by firearms. This report can be located on the Web at *http://rtckids.fmhi.usf.edu*

"School-based suicide intervention" refers to the following steps that school personnel can take when a student threatens or attempts suicide:

- *Assess the suicide risk.* The National Institute of Mental Health provides guidance for assessing whether or not someone is experiencing more than normal, everyday ups and downs in a publication titled *What to Do When a Friend Is Depressed: A Guide for Students*. It encourages young people to find out more about depression and, if they suspect someone may be thinking of suicide, talk with a trusted and respected adult or enlist the help of a professional trained in crisis management to help assess the situation.[21] The results of a randomized, controlled trial reported in the *Journal of the American Medical Association* show that students exposed to suicide questions were no more likely to report suicidal ideation after the survey than were unexposed

[19] Alonso, C., & Gurian, A. (2001, May/June). *Youth suicide, NYU Child Study Center Letter,* 5 (5).
[20] Centers for Disease Control and Prevention. (1992, September 1).*Youth suicide prevention programs: A resource guide*. Atlanta, GA: U.S. Department of Health and Human Services. *http://wonder.cdc.gov/wonder/prevguid/p0000024/p0000024.asp*
[21] *What to Do When a Friend Is Depressed: Guide for Students.* (2001). NIMH Publication No. 01-3824. *http://www.nimh.nih.gov/publicat/friend.cfm*

students. High-risk students (defined as those with depression symptoms, substance-use problems, or a previous suicide attempt) in the experimental group were neither more suicidal nor distressed than were high-risk youths in the control group.[22]

- *Ensure student safety.* In a high-risk situation the goal is to prevent the suicide attempt and move the student and others to safety, including restricting access to potentially lethal weapons or drugs. A student who threatens to commit or who attempts suicide must never be left unattended. Refrain from promising confidentiality and escort the student to an area where he/she will feel safe. Call the crisis intervention team immediately. Talk to the student, ask specific questions about the suicide plan, and document everything in writing.[23]

  The following guidance is intended to provide general information on the severity or probability of a suicide attempt and does not recommend a level of intervention needed.

  - *Extreme Risk.* Extreme risk is deemed when the student has a specific and deliberate plan, possesses a dangerous weapon or instrument to be used to carry out the plan, and will not give up the weapon or instrument voluntarily.

  - *Severe Risk.* Severe risk is deemed when the student has a specific plan for suicide. Although there is no visible weapon, he/she may have a weapon or other instrument at home.

  - *Moderate Risk.* Moderate risk is deemed when the student has verbalized suicidal ideation but has no specific plan or dangerous instrument. [24]

- *Notify parents or legal guardian(s). Education Code* Section 49602 describes the responsibility of the school counselor to maintain confidentiality of personal information. It also specifies sharing information with the school principal and parents when the school counselor believes it will avert a clear and present danger to the health, safety, or welfare of a student.

- *Provide referrals.* For students considered at moderate or severe risk of suicide, school personnel should notify the appropriate community mental health agency and request assistance. If a mental health professional is not immediately accessible, a member of the crisis team or law enforcement responder should escort the student to the nearest medical emergency facility and notify the student's parents.[25]

---

[22] Gould, M., et al. (2005). Evaluating Iatrogenic risk of youth suicide screening programs, *Journal of the American Medical Association*, 293, 1635-1643. *jama.ama-assn.org*

[23] American Association of Suicidology. (2005). *Facts About Suicide and Depression.* Washington, DC: Author. *http://www.suicidology.org*

[24] Peters, Lori J. 1985. *Teenage Suicide: Identification, Intervention and Prevention.* Ann Arbor, MI: ERIC Clearinghouse on Counseling and Personnel Services.

[25] National Institute of Mental Health: *http://www.nimh.nih.gov/publicat/depression.cfm*

- *Follow up with and support the student and family.* When the student returns to school, the school staff should assess the need for modifications to his/her school programs and make referrals to community agencies to ensure the student receives adequate support. The school staff may also ensure access to grief counselors and others, preferably on site, to listen to and support students and staff who were directly or indirectly involved with the incident at the school.[26]

- *Debrief*. Provide all who were involved with the opportunity to process feelings and concerns and to make suggestions. Evaluate the crisis, the strategies employed, and make crisis-response modifications based on the effectiveness of the each strategy used in the incident.

Recommended School-Based Suicide-Aftermath Approach

Having methods in place for dealing with a potential suicide is laudable, but just as important is the process for how to assist those affected by the completed suicide. *Education Code* Section 32260 requires schools to develop and implement comprehensive school safety plans that include a process for responding in times of crisis. Effective and safe schools address both the management and organization of the school as well as how to respond to the school community in the aftermath of tragedy.

The crisis response team (described earlier in the school-based primary suicide prevention section) must meet regularly and conduct simulation exercises in preparation for an emergency and to secure the support and involvement of federal, state, and local resources before a crisis occurs. The team must follow its process for student suicide and be prepared to step into action.

Within Three Hours of Notice of the Incident

- *Confirm the suicide.* It is important to verify that a suicide has, in fact, occurred. As soon as possible, the school principal or designee should contact first responders, such as law enforcement, the treating medical facility, or with the student's family to confirm whether the victim's demise is a result of suicide.

- *Mobilize a crisis response team.* The principal should immediately mobilize the crisis response team that has been given specific roles and duties in the aftermath.

After a suicide has occurred, the roles and duties of team members may include, but are not limited to, the following:

  - *Crisis response coordinator*. The coordinator is typically the school principal or designee and verifies the death and mobilizes the crisis response team.

[26] Ibid.

To determine the level or degree of aftermath services, he/she contacts the family to offer sympathy and assistance and inquire about the victim's close friends who may need interventions. He/she also verifies with the family what facts about the suicide can be divulged at school without agreeing to keep the suicide a secret.

- *Crisis intervention coordinator*. This coordinator is typically the school-based mental health professional, counselor, school psychologist, or social worker. He/she provides basic facts of the incident to school staff and delivers a message to each classroom (simultaneously if possible) where the teacher or other familiar staff member is present to help students. He/she also identifies individuals who need aftermath services, notifies the community mental health partner for assistance, and makes immediate intervention referrals. [27]

- *Media liaison*. The liaison is typically the school principal or district-level administrator and is the *only* spokesperson for the school or district. Ideally, he/she has already established a rapport with the press and can provide an accurate account of the event and can persuade the media not to romanticize the incident. Additionally, this person controls rumors and protects students from eager reporters. To learn more about the role of the media liaison, visit the Centers for Disease Control and Prevention, CDC Recommends, and search "suicide."[28]

- *Medical liaison.* Typically the school nurse functions in the role. It is good to have a medical liaison team member to interact with "first responders" — law enforcement, fire department, and/or medical personnel — when they arrive on the scene.

- *Security liaison*. Typically a school administrator performs this function. The security liaison ensures student safety, interacts with the "first responder" to perform crowd control, and monitors the campus areas where students are evacuated or have congregated.

[27] National Institute of Mental Health. (2001). *Helping Children and Adolescents Cope with Violence and Disasters*. *http://www.nimh.nih.gov/publicat/violence.cfm*

[28] Centers for Disease Control and Prevention. (1994). Suicide contagion and the reporting of suicide: Recommendations from a national workshop. *Morbidity and Mortality Weekly Report 43(RR 06);* 9-18. h*ttp://www.cdc.gov/mmwr/preview/ind94_rr.html*

Within 24 Hours of the Incident

- *Initiate crisis intervention services.* There is a correlation between the level of post-incident services and the level of stress among individuals who were emotionally or physically affected by the incident.[29] Whether the suicide happens at school or in the community, it is important to help the school community cope with the events of the crisis. Students, staff, parents, and others in the community should have immediate access to individuals who can respond to death and loss. Such individuals should include those familiar with the school community, its religious beliefs, and cultural values.[30] It is recommended that the school community:

    - Conduct individual and group counseling sessions, staff meetings, parent meetings, classroom activities, and community agency referrals as needed.

    - Create and maintain drop-in counseling centers on or near campus for several days following the suicide.

    - Provide the victim's classroom teacher(s) with access to mental health professionals to assist them in how best to discuss the completed suicide with students and reduce the stigma of the "empty chair."

    - Maintain careful observation of students and insist that no student leave school without his/her parent's permission. Parents should be notified if their child expresses suicidal ideation.[31]

- *Memorials.* Losing a classmate, friend, or confidant creates a mixture of emotions and grief that can cycle through several times as the adolescent continues through his/her life and experiences. It is important that those who grieve a loss understand that they are not responsible. It is important that friends and classmates of the victim have access to adult guidance and avoid depression by staying active, talking with others, writing poems or prose, or composing music.[32]

CONCLUSION

Youth suicidal behavior is often an impulsive response to circumstances rather than a wish to die. As difficult as young people's reactions are to gauge and prevent, research

[29] U.S. Public Health Service. (1999). *Surgeon General's Call to Action to Prevent Suicide.* Washington, DC: Author [p. 12]. *http://www.mentalhealth.org/suicideprevention/calltoaction.asp*

[30] U.S. Department of Education. (1998). *Early Warning, Timely Response: A Guide to Safe Schools*. Washington, DC: Author. *http://cecp.air.org/guide/guide.pdf*

[31] Los Angeles County Office of Education. N.d. *School Mental Health Crisis Intervention Teams*: *A Vital Component of School Crisis Management Using the Standardized Emergency Management System*. *http://www.lacoe.edu/lacoeweb/orgs/158/index.cfm*

[32] Northern County Psychiatric Associates. *http://www.baltimorepsych.com*

findings support the need for school-based efforts to help students cope with stressors and avoid substance abuse and violent confrontations.

Suicide-prevention efforts that address risk factors and incorporate adult and peer support will help school counselors, teachers, nurses, administrators, and students to recognize and respond to risk factors and behavioral indicators for suicide.

Adults in the school can better ensure the health and safety of their students by taking the following actions:[33]

- Model safety and respect.
- Get training to recognize when someone is in distress and to intervene in preventing an unintentional injury, violence, or suicide.
- Understand how to contact agencies in the community that have programs designed to reduce stress and strengthen coping skills.

Grounds and custodial staff members, bus drivers, administrators, counselors, and other staff members can join in and support such efforts.

[33] Centers for Disease Control and Prevention. (2001). School health guidelines to prevent unintentional injuries and violence. *Morbidity and Mortality Weekly Report* 50 (RR 22) 46. *http://www.cdc.gov/mmwr/indrr_2001.html*

WEB RESOURCES

- Center for Suicide Prevention
  http://www.suicideinfo.ca

- Centers for Disease Control and Prevention (CDC) National Youth Violence Prevention Resource Center
  http://www.safeyouth.org/home.htm

- International Academy for Suicide Research
  http://www.uni-wuerzburg.de/IASR

- National Center for Suicide Prevention Training
  http://www.ncspt.org

- National Library of Medicine
  http://www.mentalhealth.org/suicideprevention

- Northern County Psychiatric Associates, Baltimore County, Maryland
  http://www.baltimorepsych.com

- *The Surgeon General's Call to Action to Prevent Suicide* (1999)
  http://www.mentalhealth.org/suicideprevention/calltoaction.asp
  Schools can be referral points for children's mental and physical health. The companion action plan entitled *National Strategy for Suicide Prevention: Goals and Objectives* has 11 goals accompanied by 68 objectives.
  http://www.surgeongeneral.gov/library/calltoaction/default.htm

- University of California, Los Angeles School of Mental Health, Resource and Technical Aid Packets
  http://smhp.psych.ucla.edu/techpak.htm#suicide

- Web-based Injury Statistics Query and Reporting System (WISQARS) on the CDC's National Center for the Injury Prevention and Control Web site
  http://www.cdc.gov/ncipc/wisqars/default.htm